

**Commonwealth of Kentucky**  
**Cabinet for Health and Family Services**  
**Department for Medicaid Services**  
**MEMORANDUM**

TO: \_\_\_\_\_ County Office  
(Department for Community Based Services)

FROM: \_\_\_\_\_  
(Facility/Waiver Agency) (Provider Number)

DATE: \_\_\_\_\_

SUBJECT: \_\_\_\_\_  
(Recipient Name) (Social Security Number)

\_\_\_\_\_  
(Previous Address)

\_\_\_\_\_  
(City) (State) (ZIP)

\_\_\_\_\_  
(Responsible Relatives Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (ZIP)

**This is to notify you that the above referenced recipient:**

☐ was admitted to this facility/waiver agency on \_\_\_\_\_ is in Title \_\_\_\_\_  
(Date) (XVIII or XIX)

Placement Status, and was placed in a:

- |  |   |
|--|---|
| <input type="checkbox"/> NF Bed        | <input type="checkbox"/> Home and Community Based Services (HCBS)     |
| <input type="checkbox"/> ICF/MR/DD Bed | <input type="checkbox"/> Supports for Community Living (SCL) Services |
| <input type="checkbox"/> MH Bed        | <input type="checkbox"/> Michelle P. Waiver Services                  |
| <input type="checkbox"/> ESPDT Bed     |   |

☐ was discharged from this facility/waiver on \_\_\_\_\_ and went to \_\_\_\_\_  
(Date) (Name of Facility)

\_\_\_\_\_  
(Home Address or Name and Address of New Facility/Waiver Agency)

\_\_\_\_\_  
(City) (State) (ZIP)

and or expired on \_\_\_\_\_  
(Date)

☐ was reinstated to HCBS, SCL, Michelle P. waiver services within 60 days of the Nursing Facility admission \_\_\_\_\_  
(Date re-instated)

**For HCB and Michelle P. waiver clients only** – Last date service was provided \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature)